

**OCCUPATIONAL HEALTH SERVICES**

**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

**T**he following information must be provided by every workforce member who has been selected to use any type of respirator. The Occupational Health Services will treat all information you provide in a confidential manner. (***Please Print***).

**PART A: SECTION 1**.

1. **Today's Date**: \_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_

2. **Your Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. **Your Age (to nearest year**): \_\_\_\_\_

4. **Sex**: [ ]  **Male** [ ] Female

5. **Your Height**: \_\_\_\_\_\_\_ ft. \_\_\_\_\_\_\_ in.

6. **Your Weight**: \_\_\_\_\_\_\_\_ lbs.

7. **Your Job Title**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Supervisor’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. **Department**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Extension/Beeper**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. **A phone number where you can be reached by the health care provider who reviews this**

 **questionnaire**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Best time to reach you at this number? \_\_\_\_\_\_\_\_\_\_*

10. **Check the type of respirator you will use**: (*You can check more than one category if*

 *applicable*):

 [ ] Disposable Respirator N95

 [ ] PAPR (Powered-Air Purifying Respirator)

11. **Have you ever worn a respirator**? [ ]  Yes[ ]  No

 **If so, what types(s):**

[ ]  N95

 [ ]  Half or Full-Face Respirator

 [ ]  PAPR (Powered-Air Purifying Respirator)

 [ ]  SCBA (Self-Contained Breathing Apparatus)

12. **Are you allergic to latex?** [ ]  Yes [ ] No

**DFCI OCCUPATIONAL HEALTH SERVICE**

**PART A. SECTION 2**. Questions 1 - 9 must be answered by every workforce member who has been selected to use any type of respirator (***Please place a check mark in the “YES” or “NO”******column***.)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **QUESTION** | **YES** | **NO** |
| **1.** | Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? |[ ] [ ]
|  |  |  |  |
| **2.** | Have you **ever had** any of the following conditions? |[ ] [ ]
|  | a. Seizures (fits)  |[ ] [ ]
|  | b. Diabetes (blood sugar disease)  |[ ] [ ]
|  | c. Allergic reactions that interfere with your breathing  |[ ] [ ]
|  | d. Claustrophobia (fear of closed-in places) |[ ] [ ]
|  | e. Trouble smelling odors |[ ] [ ]
|  |  |  |  |
| **3.** | Have you **ever had** any of the following pulmonary or lung problems? | **YES** | **NO** |
|  | a. Asbestosis |[ ] [ ]
|  | b. Asthma (**If so, please complete asthma history below**) 1. In the last month, have you had asthma symptoms (*cough,*

 *wheeze, shortness of breath, chest tightness*) more than twice  a week? [ ]  **Yes** [ ]  **No** 1. In the last month, have asthma symptoms woken you up at night or earlier than usual in the a.m. more than twice a week?

 [ ]  **Yes** [ ]  **No** 1. In the last month, have you used your rescue inhaler (*such as* *albuterol*) more than twice a week? [ ] **Yes** [ ] **No**
2. If you currently use a respirator, is it difficult to wear when you have asthma symptoms? [ ] **Yes** [ ]  **No**
 |  |  |
|  | c. Chronic Bronchitis |[ ] [ ]
|  | d. Emphysema |[ ] [ ]
|  | e. Pneumonia |[ ] [ ]
|  | f. Tuberculosis (TB) |[ ] [ ]
|  | g. Silicosis |[ ] [ ]
|  | h. Pneumothorax (collapsed lung) |[ ] [ ]
|  | i. Lung Cancer |[ ] [ ]
|  | j. Broken Rib(s) |[ ] [ ]
|  | k. Any chest injuries or surgeries? |[ ] [ ]
|  | l. Any other lung problem that you've been told about? |[ ] [ ]
|  |  |  |  |
| **4.**  | Do you **currentl**y have any of the following symptoms of pulmonary or lung illness? | **YES** | **NO** |
|  | 1. Shortness of breath
 |[ ] [ ]
|  | **QUESTION** | **YES** | **NO** |
|  | b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline |[ ] [ ]
|  | c. Shortness of breath when walking with other people at an ordinary pace on level ground |[ ] [ ]
|  | d.Have to stop for breath when walking at your own pace on level ground |[ ] [ ]
|  | e. Shortness of breath when washing or dressing yourself |[ ] [ ]
|  | f. Shortness of breath that interferes with your job |[ ] [ ]
|  | g. Coughing that produces phlegm (thick sputum) |[ ] [ ]
|  | h. Coughing that wakes you early in the morning |[ ] [ ]
|  | i. Coughing that occurs mostly when you are lying down |[ ] [ ]
|  | j. Coughing up blood in the last month |[ ] [ ]
|  | k. Wheezing |[ ] [ ]
|  | l. Wheezing that interferes with your job |[ ] [ ]
|  | m. Chest pain when you breathe deeply |[ ] [ ]
|  | n. Any other symptoms that you think may be related to lung problems |[ ] [ ]
|  |  |  |  |
| **5.** | Have you **ever had** any of the following cardiovascular or heart problems? | **YES** | **NO** |
|  | a. Heart Attack  |[ ] [ ]
|  | b. Stroke |[ ] [ ]
|  | c. Angina |[ ] [ ]
|  | d. Heart Failure | [ ]  | [ ]  |
|  | e. Swelling in your legs or feet (not caused by walking) | [ ]  | [ ]  |
|  | f. Heart Arrhythmia (heart beating irregularly) | [ ]  | [ ]  |
|  | g. High Blood Pressure |[ ] [ ]
|  | h. Any other heart problem that you've been told about  |[ ] [ ]
|  |  |  |  |
| **6.** | Have you **ever had** any of the following cardiovascular or heart symptoms? | **YES** | **NO** |
|  | a. Frequent pain or tightness in your chest |[ ] [ ]
|  | b. Pain or tightness in your chest during physical activity |[ ] [ ]
|  | c. Pain or tightness in your chest that interferes with your job |[ ] [ ]
|  | d. In the past two years, have you noticed your heart skipping or  missing a beat |[ ] [ ]
|  | e. Heartburn or indigestion that is not related to eating  |[ ] [ ]
|  | f. Any other symptoms that you think may be related to heart or  circulation problems |[ ] [ ]
|  |  |  |  |
| **7.** | Do you **currently** take medication for any of the following problems? | **YES** | **NO** |
|  | a. Breathing or lung problems |[ ] [ ]
|  | b. Heart trouble |[ ] [ ]
|  | c. Blood Pressure |[ ] [ ]
|  | d. Seizures |[ ] [ ]
|  |  |  |  |
|  | **QUESTIONS** | **YES** | **NO** |
| **8.** | If you've used a respirator, have you **ever had** any of the following problems while wearing a respirator?  **If you've never used a respirator, check here** [ ]  **and go to question 9.**  |  |  |
|  | a. Eye Irritation |[ ] [ ]
|  | b. Skin Allergies or Rashes |[ ] [ ]
|  | c. Anxiety |[ ] [ ]
|  | d. General weakness or fatigue |[ ] [ ]
|  | e. Any other problem that interferes with your use of a respirator |[ ] [ ]
|  |  |  |  |
| **9.**  | Would you like to talk to the healthcare professional who will review this questionnaire about your answers to the questionnaire? |[ ] [ ]
|  |  |  |  |
|  | ***Questions 10 - 15 must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees using other types of respirators, answering these questions is voluntary.*** |  |  |
| **10.** | Have you **ever** lost vision in either eye (temporarily or permanently)? |[ ] [ ]
|  |  |  |  |
| **11.** | Do you **currently** have any of the following vision problems? | **YES** | **NO** |
|  | a. Wear Contact Lenses  |[ ] [ ]
|  | b. Wear Glasses |[ ] [ ]
|  | c. Color Blind |[ ] [ ]
|  | d. Any other eye or vision problem |[ ] [ ]
|  |  |  |  |
| **12.** | Have you **ever had** an injury to your ears, including a broken ear drum? |[ ] [ ]
|  |  |  |  |
| **13.** | Do you **currently** have any of the following hearing problems? | **YES** | **NO** |
|  | a. Difficulty Hearing |[ ] [ ]
|  | b. Wear a Hearing Aid |[ ] [ ]
|  | c. Any other Hearing or Ear Problem |[ ] [ ]
|  |  |  |  |
| **14.** | Have you **ever had** a back injury? |[ ] [ ]
|  |  |  |  |
| **15.**  | Do you **currently** have any of the following musculoskeletal problems? | **YES** | **NO** |
|  | a. Weakness in any of your arms, hands, legs, or feet |[ ] [ ]
|  | b. Back pain  |[ ] [ ]
|  | c. Difficulty fully moving your arms and legs |[ ] [ ]
|  | d. Pain or stiffness when you lean forward or backward at the waist |[ ] [ ]
|  | e. Difficulty fully moving your head up or down |[ ] [ ]
|  | f. Difficulty fully moving your head side to side |[ ] [ ]
|  | g. Difficulty bending at your knees |[ ] [ ]
|  | h. Difficulty squatting to the ground |[ ] [ ]
|  | i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.  |[ ] [ ]
|  | j. Any other muscle or skeletal problem that interferes with using a  respirator  |[ ] [ ]

|  |
| --- |
| **PART**  **PART B – OHS Use Only:** 🞎 [ ]  Medically Cleared for Respirator Use Without Restrictions  [ ]  Medically Cleared for Respirator Use **with following restrictions for**: [ ] N95 [ ] PAPR1. [ ] No Respirator use if wheezing or shortness of breath evident
2. [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ]  Pending PCP or Treating Specialist Recommendation Date of Request: \_\_\_ /\_\_\_ /\_\_\_\_\_\_\_  [ ]  Pending OHS Physician Review🞎 [ ]  Not Medically Cleared to Wear a Respirator**OHS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****OHS OHS CLINICIAN SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_ /\_\_\_ /\_\_\_\_\_\_\_\_ |